Connecticut Association for
HOME CARE
& HOSPICE

TESTIMONY BEFORE THE HUMAN SERVICES COMMITTEE REGARDING
S.B. 843 – AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET
RECOMMENDATIONS CONCERNING SOCIAL SERVICES

March 3, 2009

Senator Doyle, Representative Walker, and members of the Human Services Committee, my name is Brian Ellsworth and I am President & CEO of the Connecticut Association for Home Care & Hospice (CAHCH), whose members serve over 100,000 elderly, disabled, and terminally ill Connecticut citizens. The Association appreciates this opportunity to speak to you about how the Governor's budget recommendations affect home care & hospice.

MEDICAID HOME CARE RATES ARE GROSSLY INADEQUATE

The Governor's proposed budget omits an increase in the Medicaid rates for home care providers. Unfortunately, the rates for home health services are approximately 30 percent below costs for the typical agency (see attached chart). This longstanding problem is now being compounded by Medicare's decision to freeze home health rates for a four-year period. Home care agencies continue to face increased wage costs due to workforce shortages, as well as double-digit annual growth in health insurance and staff mileage reimbursement costs.

This unsustainable situation is rapidly reaching a crisis point, with significant implications for patients, their families and taxpayers.

In 2007, the CT Home Care Program for Elders saved the State $91 million dollars through prevention or delay of admission to nursing homes.[1] More savings are possible, but not without adequate rates. The Association has very specific proposals for rate increases (outlined below) that we believe will be offset by significant long-run savings, a viewpoint shared by a recent article published in the respected journal, *Health Affairs*.[2]

[1] Annual Report by DSS on the CT Home Care Program for Elders - CT's Medicaid waiver program.
[2] "Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?" *Health Affairs*, January 2009.

Specific Proposals Regarding Medicaid Rates

- Equalize Medicaid Rates to Medicare: Increase Medicaid base rates for skilled nursing visits, home health aide services, and therapies to the per visit rates used by the Medicare program by the end of the biennium, with half implemented in 2009 and the other half in 2010.

- Provide Funds to Financially Distressed Agencies: Design a means for home care providers to access the "distressed" facility funds, and a mechanism for "interim rate adjustments" as accorded to hospitals and nursing homes, and implement in 2009.

- Increase Medicaid Rates for Behavioral Home Care: Increase Medicaid rates for Medication Administration by the Consumer Price Index – Urban.

- Increase Medicaid Rates for Homemaker-Companion Services: Increase Medicaid rates for Homemaker-Companion services by the Consumer Price Index – Urban.

- Increase Medicaid Rates for Extended Nursing/Shift Care: Significantly increase the Medicaid rates for shift/extended hourly nursing so that they are equivalent to per visit skilled nursing.

- Permit Medicaid Billing for Vaccinations: Home health agencies should be able to bill Medicaid for flu shots through an approach similar to the Medicare program, including a fee for both the administration and the vaccine based on the rates utilized by Medicare.

- Authorize Medicaid Coverage for Telemonitoring: Include telemonitoring in the list of waiver services for the CT Home Care Program for Elders and amend the State Medicaid Plan to include telemonitors for Medicaid-only patients at risk of hospitalization due to chronic illness.

NECESSITY TO MAINTAIN COMMITMENT TO SYSTEM REFORM

The Association **opposes** Sections 55 through 58 of S.B. 843, which propose a two-year delay in the implementation of the Long Term Care Reinvestment Account and delay plans for expanding efforts to divert persons from institutions. Instead of delay, CAHCH advocates that funding for the Long Term Care Reinvestment Account be increased to include additional federal funds from converting state-funded persons to Medicaid and increasing the rate of diversion of people from nursing homes -- *see substitute language for Section 57 in Attachment B.*

Laudable programs, such as "Money Follows the Person" will have diminished chances for success unless inadequate Medicaid rates are expeditiously addressed. If that program fails, CT will forego $24 million in increased federal funds for the first 700 transitions from institutions to home over the next several years.

MEDICAID COVERAGE OF TELEMONITORS

Governor Rell's budget proposes to allow Medicaid coverage of telemonitoring services provided by home health agencies, including coverage for the cost of equipment rental and 24-hour monitoring for patients with congestive heart failure or chronic obstructive pulmonary disease who meet certain medical criteria. CAHCH **strongly supports** this proposal, but is concerned that there is no statutory language in S.B. 843. CAHCH strongly advocates for statutory change so that details of the intended program are clear to all parties – *see suggested language in Attachment C.*

PROPOSAL TO MANDATE RCHS TO HAVE UNLICENSED PERSONNEL ADMINISTER MEDICATIONS

Section 62 of S.B. 843 once again proposes that Residential Care Homes (RCHs) be required to employ certified unlicensed personnel to administer medications. As we have over the last several years, the Association **opposes** this mandate because it will reduce quality of care in these homes and it is penny-wise and pound-foolish.

The current hybrid model, which allows for the use of either certified unlicensed personnel in RCHs and/or home health nurses to make medication administration visits, provides for much needed flexibility for RCHs that serve differing patient populations. Most RCHs do not have nursing staff available to supervise these unlicensed persons, or to make a clinical determination as to whether or not a medication should be administered or if any further follow up should occur, including reassessment or contacting a physician. This can result in significant care or safety issues, especially for residents with multiple chronic conditions.

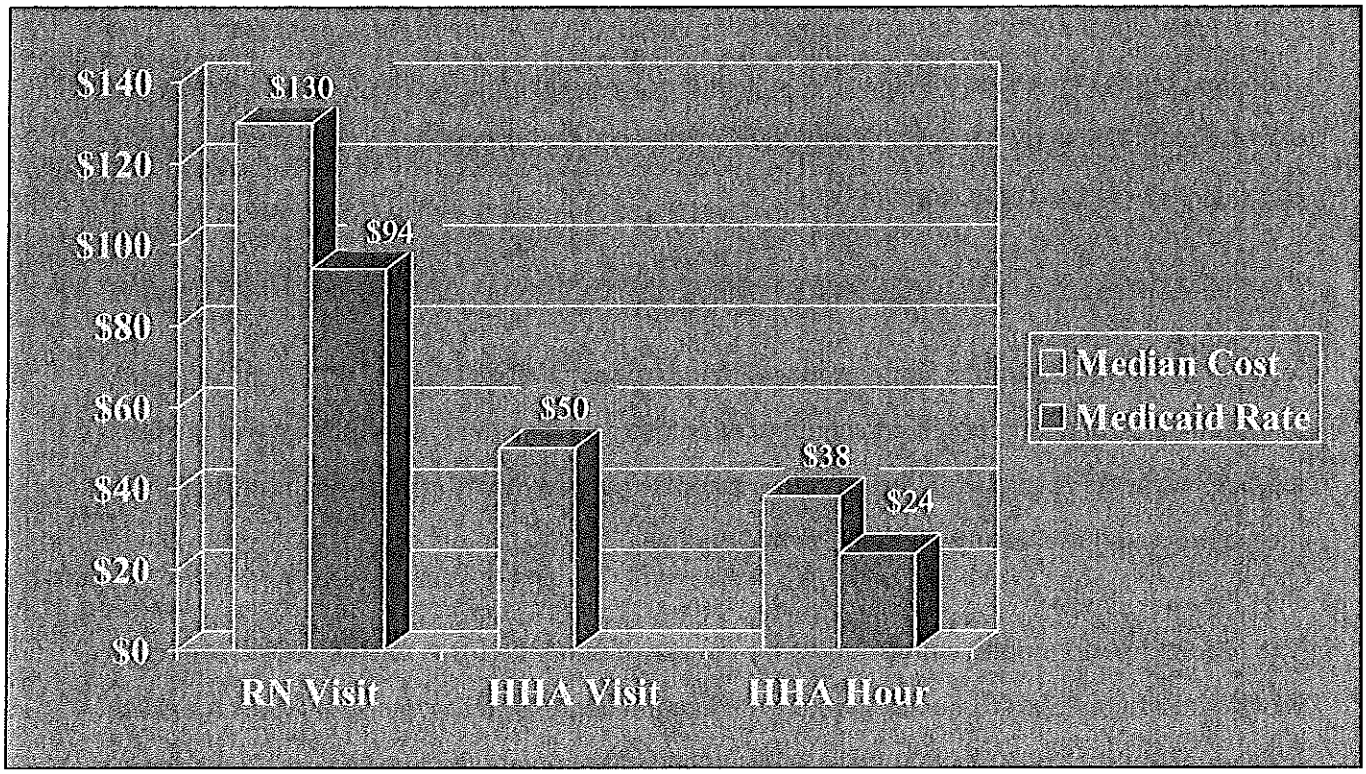
The Governor's proposal is not likely to yield significant savings. In the long run, RCHs will either have to increase their staff, or there will be an increase in unnecessary hospitalizations.

The Association urges the General Assembly, as it has done so for the last several years, to reject this short-sighted and ill-advised proposal and instead to work with RCHs and home care agencies on ways to further collaborate to improve the quality of care to this vulnerable population. There is no need for an additional mandate on already under-funded rest homes.

Thank you for consideration of our comments. I would be pleased to answer any questions you may have.

ATTACHMENT A

Medicaid Cost Per Visit Analysis



Source: 42 Home Health Agency Medicare Cost Reports with June 30, 2007 FYE and [illegible] FYE

ATTACHMENT B

Proposed Substitute Language for Section 57 of S.B. 843

Section 57. Subsection (a) of section 17b-371 of the general statutes, as amended by section 1 of public act 09-1, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2009*):

(a) On July 1, 2009, to the extent permitted by federal law, there shall be established within the General Fund, a separate, nonlapsing account which shall be known as the "Long-Term Care Reinvestment account". The account shall contain any moneys required by law and this section to be deposited in the account. Any funds resulting from: (1) the enhanced federal medical assistance percentage received by the state under the Money Follows the Person demonstration project pursuant to Section 6071 of the Deficit Reduction Act of 2005, (2) federal reimbursement for persons who become eligible for medical assistance as a result of implementation of the demonstration project described in public act 08-180 and who previously would have met the financial eligibility criteria for the state-funded portion of the Connecticut home-care program for the elderly pursuant to section 17b-342 of the general statutes and (3) the estimated savings from diverting persons from nursing facility care under such demonstration project. Such savings shall be calculated by subtracting the costs of home and community based care under the demonstration from costs of nursing facility care, reduced by thirty-five percent, for all persons newly receiving home and community-based care under the demonstration.

ATTACHMENT C

Proposed Language for Medicaid Coverage of Telemonitors

(NEW) (*Effective July 1, 2009*) On or before January 1, 2010, the Department of Social Services shall a establish fee schedule and billing codes for payments to home health agencies that provide telemonitors to Medicaid eligible and state-funded persons in the community with chronic conditions, including but not limited to: (1) congestive heart failure, (2) diabetes or (3) chronic obstructive pulmonary disease. The Commissioner shall ensure that patients selected to receive telemonitoring services by a home health agency shall be evaluated for (1) the nature of the patient's medical condition and whether such medical condition requires skilled nursing visits that could be reduced through telemonitoring or if the patient has had a history of frequent hospitalizations or emergency room use over the prior twelve months, (2) the patient's cognitive ability and support system, and (3) whether the patient resides in a medically underserved area. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54 of the general statutes, to carry out the provisions of this subsection and may, while in the process of adopting such regulations, implement policies and procedures necessary to administer the provisions of this subsection, provided that the Commissioner prints notice of the intent to adopt the regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policies and procedures shall be valid until the time final regulations are adopted.

Subsection (c) of Section 17b-342 of the general statutes is amended as follows (*Effective July 1, 2009*):

(c) The community-based services covered under the program shall include, but not be limited to, the following services to the extent that they are not available under the state Medicaid plan, occupational therapy, homemaker services, telemonitoring, companion services, meals on wheels, adult day care, transportation, mental health counseling, care management, elderly foster care, minor home modifications and assisted living services provided in state-funded congregate housing and in other assisted living pilot or demonstration projects established under state law. Recipients of state-funded services and persons who are determined to be functionally eligible for community-based services who have an application for medical assistance pending shall have the cost of home health and community-based services covered by the program, provided they comply with all medical assistance application requirements. Access agencies shall not use department funds to purchase community-based services or home health services from themselves or any related parties.